MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

7818

File No. 2188
Registered No.

Registration District No. 791 1003
Primary Registration District No.

1. PLACE OF DEATH

County
Township
City St Louis Mo (No. City Hospital #2 St. Ward)

2. FULL NAME OLLIE ALEXANDER

(a) Residence. No. 7164 WASHINGTON St., 23 Ward. St Louis Co. Mo
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	C	SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4 — 8 — 1902

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	28	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: COOK
(b) General nature of industry, business, or establishment in which employed (or employer): DOMESTIC —
(c) Name of employer: SERVANT

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) ARKANSAS

PARENTS
10. NAME OF FATHER ED GUYTON
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) MISS
12. MAIDEN NAME OF MOTHER ADA NEWTON
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) MISS

14. INFORMANT A. GERTRUDE CREATH
(Address) City Hospital #2

15. FILED 19 Mar C Harter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 — 14 — 1931

17. I HEREBY CERTIFY, That I attended deceased from 2 — 7 —, 1931, to 2 — 14 —, 1931 that I last saw h. alive on 2 — 14 —, 1931, and that death occurred, on the date stated above, at 9.00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

LOBAR PNEUMONIA

108 (duration) yrs. mos. 11 ds.

CONTRIBUTORY (SECONDARY) UNKNOWN

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH AT HOME

DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? CLINICAL-X-RAY-LAB

(Signed) Henry G. Hampton, M. D.

2-15-, 1931 (Address) City Hosp. #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forrest City, Ark.

DATE OF BURIAL 2-18 1931

20. UNDERTAKER J. E. Pope

ADDRESS 2931 Lucas Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD